DEPARTMENT OF THE NAVY
BUREAU OF MEDICINE AND SURGERY
2300 E STREET NW
WASHINGTON DC 20372-5300

Canc frp: Dec 2004

IN REPLY REFER TO
BUMEDNOTE 5353
BUMED-M3M2
1 Dec 2003

BUMED NOTICE 5353

From: Chief, Bureau of Medicine and Surgery
To: All Ships and Stations Having Medical Department Personnel

Subj: STANDARDIZATION OF SUBSTANCE ABUSE REHABILITATION PROGRAM INTAKE, TREATMENT, DISCHARGE, AND CONTINUING CARE FORMS

Ref: (a) OPNAVINST 5350.4
(b) BUMEDINST 5353.4

Encl: (1) SARP Treatment Record, Left Cover Page NAVMED 5353/2 (5-2003)
(2) SARP Record of Disclosure, NAVMED 5353/3 (5-2003)
(3) SARP Voluntary Consent to Drug and Alcohol Testing, NAVMED 5353/4 (5-2003)
(4) SARP Treatment Intake, NAVMED 5353/5 (5-2003)
(5) SARP Individual Treatment Plan Master Problem List, NAVMED 5353/6 (5-2003)
(6) SARP Audio/Video Consent Form, NAVMED 5353/7 (5-2003)
(7) SARP Clinical Progress Note, NAVMED O/P 5353/8 (5-2003)
(8) SARP Consent to Obtain Information, NAVMED 5353/9 (5-2003)
(9) SARP Treatment Record Right Cover Page, NAVMED 5353/10 (5-2003)
(10) SARP Privacy Act Statement, NAVMED 5353/11 (5-2003)
(11) SARP Patient Information, NAVMED 5353/12 (5-2003)
(12) SARP Alcohol and Drug Assessment, NAVMED 5353/13 (5-2003)
(13) SARP Consultation Sheet, NAVMED O/P 5353/14 (5-2003)
(14) SARP Significant Other Contact Authorization, NAVMED 5353/15 (5-2003)
(15) SARP Information Release Authorization, NAVMED 5353/16 (5-2003)
(16) SARP Informed Consent, NAVMED O/P 5353/17 (5-2003)
(17) SARP Recommended Continuing Care Plan, Sample Format 1
(18) SARP Referral Form, Sample Format 2

1. Purpose. To announce standard intake, treatment, discharge, and continuing care forms for use at all USN Substance Abuse Rehabilitation Program (SARP) facilities.

2. Background. Reference (a) provides guidance to all personnel in Drug and Alcohol Abuse Prevention and Control. Reference (b) provides guidance for Standards for Provision of Substance Related Disorder Treatment Services. Enclosures (1) through (18) will provide a standard mechanism for intake documentation for patients seeking substance abuse treatment services.

3. Action. Use the enclosed forms to record treatment in our Substance Abuse Rehabilitation Programs. A phase-in period of 2 months from the date of this note is allowed.

4. Point of Contact. Mr. Charles Gould, Drug and Alcohol Program Manager, at (202)762-1738, DSN 762-1738, e-mail CLGould@US.MED.NAVY.MIL.

5. Forms. Enclosures (1) through (16) are available via the Bureau of Medicine and Surgery Web site at http://nmo.med.navy.mil/default.cfm?seltab=directives at the "Forms" tab. Enclosures (17) and (18) are available in Word format at the "Forms" tab. Local reproduction is authorized.

6. Cancellation Contingency. Retain until incorporated into BUMEDINST 5353.4.

K. L. Martin

K. L. MARTIN
Vice Chief

Available at: http://nmo.med.navy.mil/default.cfm?seltab=directives

SUBSTANCE ABUSE REHABILITATION PROGRAM TREATMENT RECORD

LEFT COVER PAGE

_____ Record of Disclosure

_____ Treatment Enrollment Letter (Facility Specific – No Sample Provided)

_____ Voluntary Consent To Drug and Alcohol Testing

_____ Treatment Intake

_____ Individual Treatment Plan

_____ Audio/Video Consent Form

_____ Treatment Completion/Disenrollment Letter (Facility Specific – No Sample Provided)

_____ Continuing Care Enrollment Letter (Facility Specific – No Sample Provided)

_____ Recommended Continuing Care Plan

_____ Continuing Care Completion Letter (Facility Specific – No Sample Provided)

_____ Clinical Progress Note (Sample Provided)

_____ Performance Improvement (Facility Specific - No Sample Provided)

_____ Consent to Obtain Information

_____ Additional Pertinent Information

All items checked above can be found in this clinical package in the order they are listed. For whatever reason forms are removed, they should be replaced as soon as possible. Any information disclosed by authorization will be so noted on the Disclosure Accounting Form.

SUBSTANCE ABUSE REHABILITATION PROGRAM

RECORD OF DISCLOSURE

UNAUTHORIZED DISCLOSURE OF PERSONAL INFORMATION FROM
THIS RECORD COULD SUBJECT THE DISCLOSURE TO CRIMINAL PENALTIES

1. This is to remain a permanent part of the record described below.
2. An entry must be made each time the record or any information from the record is viewed by, or furnished to any person or agency, except:
   a. Disclosure to DOD or DON personnel having a need to know in the performance of their official duties.
   b. Disclosure of items listed in paragraphs 14b(2)(e) and (f) of SECNAVINST 5211.5.

TITLE & DESCRIPTION OF RECORD			
DATE OF DISCLOSURE	METHOD OF DISCLOSURE	PURPOSE OR AUTHORITY	NAME & ADDRESS OF PERSON OR AGENCY TO WHOM DISCLOSED, WITH SIGNATURE IF MADE IN PERSON

Patient Name		Rank/Grade	Sex
SSN/Identification Number	Status	Date of Birth	
Branch of Service	Organization		
Sponsor's Name	Relationship to Sponsor		

SUBSTANCE ABUSE REHABILITATION PROGRAM

VOLUNTARY CONSENT TO DRUG AND ALCOHOL TESTING

To ensure patient safety and accurately assess patient needs, SARP _____ requires accurate information about the use of drugs and alcohol for those eligible beneficiaries receiving services at our facility.

I, _____ voluntarily consent to, and authorize the treatment staff at SARP, _____ to collect and conduct drug and alcohol testing while receiving services at this facility.

I further understand that drug and alcohol test results may be used for any purpose, including disciplinary action and characterization of service in separation proceedings. I also understand I have the right to decline to provide a voluntary sample for drug and alcohol testing under voluntary consent rules.

Name_____SSN_____

Signature_____ Date_____

Staff Name_____

Signature_____ Date_____

Patient Name		Rank/Grade	Sex
SSN/Identification Number	Status	Date of Birth	
Branch of Service	Organization		
Sponsor's Name	Relationship to Sponsor		

SUBSTANCE ABUSE REHABILITATION PROGRAM

TREATMENT INTAKE

PRIVACY LIMITATIONS: Practitioners at SARP do their utmost to maintain confidentiality; however, laws and regulations require us to report serious matters such as suspected child abuse and homicidal intent. Audiovisual taping of some sessions occurs only for the purpose of supervision. We will make medical record entries and report very limited information to a BUPERS tracking system. For safety, a random urinalysis or breathalyzer might be used. The involvement of a spouse or significant other in a patient's treatment could be of tremendous value. We would like your authorization to contact them. Available for your review is an eight-page notice of Military Health System Privacy Practices. I do/do not authorize you to contact _____.

Concerns I have about these Privacy Limitations are as follows:

Signature_____ Date_____

1. Physical/Medical

Please use the scale below to describe any physical pain you are currently experiencing:

0	1	2	3	4	5	6	7	8	9	10
No Pain				Moderate Pain				Worst Possible Pain		

Have you been maintaining a relatively normal diet? YES or NO
If NO, please explain: _____

2. Family/Relationships

What is your cultural background? _____

Do you have any ethnic/racial/cultural beliefs, issues, or sensitivities that would help your counselor know and understand you better? YES or NO
If YES, please explain: _____

_____

Where were you born/raised? _____

Who raised you? _____

How many brothers do you have? _____

How many sisters do you have? _____

Describe your childhood. _____

_____

Patient Name		Rank/Grade	Sex
SSN/Identification Number	Status	Date of Birth	
Branch of Service	Organization		
Sponsor's Name	Relationship to Sponsor		

TREATMENT INTAKE *(Cont'd.)*

When growing up, how were you disciplined? _____

Have you ever been physically/sexually/emotionally abused? YES or NO
If YES, please explain:_____

_____

Have you ever physically/sexually/emotionally abused anyone? YES or NO
If YES, please explain: _____

_____

Have you, or any member of your family, ever been referred to a family advocacy program because of physical or sexual abuse and/or violence? YES or NO

Are you currently living with your spouse or significant other? YES or NO
If NO, please explain_____

_____

Are you currently having problems in your relationship? YES or NO
If YES, please explain: _____

_____

How many times have you been married? _____

Date of marriage	Date of divorce/death	Reason the marriage ended
_____	_____	_____
_____	_____	_____

Do you have any children? YES or NO
If YES, what are there ages and gender?_____

_____

Are your children living with you? YES or NO
If NO, please explain:_____

Do your children have any physical, emotional, or psychological problems, disabilities, or challenges? YES or NO
If YES, please explain:_____
Do you have any extended family members living with you? (parents, siblings) YES or NO

Patient Name	Rank/Grade	Sex

SUBSTANCE ABUSE REHABILITATION PROGRAM

TREATMENT INTAKE *(Cont'd.)*

3. Social support

Who would you say really cares about you? _____

Have you recently withdrawn from friends or family? YES or NO
If YES, please explain: _____

Do you belong to any groups or organizations that are supportive and helpful to you? YES or NO
If YES, which groups? _____

4. Perception of own strengths and weaknesses

What do you like about yourself?

_____

What do you dislike about yourself?

_____

What would you change about yourself?

_____

_____

5. Spirituality

Do you believe in a concept of God/a supreme being/a higher power of some kind? YES or NO

Has your belief about God/supreme being/higher power changed during your lifetime? YES or NO
If YES, please explain: _____

Please explain your spiritual or religious practices. _____

_____

Would you like spiritual / religious support? YES or NO
If YES, please explain: _____

_____

6. Education

Circle the highest level of education you have completed:
elementary school, junior high/middle school, high school, vocational/technical school, some college, 2-year college degree, 4-year college degree, graduate degree, Ph.D. other: _____

What type of grades did you receive: ___poor___ average___ good___ excellent

Describe any learning difficulties you may have and your preferred method of learning.

_____

What type of school activities were you involved in_____

Patient Name	Rank/Grade	Sex

TREATMENT INTAKE *(Cont'd.)*

Did you have any disciplinary problems in school: YES or NO
If YES, please explain:_____

Do you have any limitations that would hinder your ability to participate in treatment?
(i.e. difficulty hearing, seeing, reading, writing) YES or NO
If YES, please explain: _____

Are you currently taking education/college courses? YES or NO

If NO, do you want to start taking education/college courses? YES or NO

7. Legal

Have you ever been arrested or detained? YES or NO
If YES, please indicate below

Date of arrest or detainment	Reason/Charges	Was alcohol or drugs a contributing factor to your arrest or detainment
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you currently on probation/parole? YES or NO
If YES, please explain:_____

Do you presently have any other legal problems? YES or NO
If YES, please explain: _____

8. Sexuality

Have you had any sexual problems? YES or NO
If YES, please explain: _____

Do you engage in unsafe sex? YES or NO

Has any past or current sexual behavior gotten you in trouble? YES or NO

9. Leisure/Recreational

What are your recreational activities?

_____

_____

Do you engage in any of these activities while using alcohol or drugs? YES or NO

Are you frequently bored? YES or NO
If YES, please explain:_____

10. Vocational History

What is your current job? _____

Patient Name	Rank/Grade	Sex

SUBSTANCE ABUSE REHABILITATION PROGRAM

TREATMENT INTAKE *(Cont'd.)*

Are you having problems with your current job? YES or NO
If YES, please explain:_____

_____

Describe your job history. _____

_____

_____

11. Financial

Do you currently have any financial problems? YES or NO
If YES, please explain:_____

_____

Do you gamble? YES or NO
If YES, how often: _____

Would you like to receive financial counseling? YES or NO

Are you currently receiving any financial assistance? YES or NO

12. If you would like, use this space to provide any additional information you feel is important.

Patient Signature _____ Date_____

Patient Name	Rank/Grade	Sex

SUBSTANCE ABUSE REHABILITATION PROGRAM

INDIVIDUAL TREATMENT PLAN
MASTER PROBLEM LIST

DATE	Prob. #	Dimension	Problem Summary List	Codes O/R/D/C

Codes
O=Open//R=Referred//D=Deferred//C=Closed

Patient Name		Rank/Grade	Sex
SSN/Identification Number	Status	Date of Birth	
Branch of Service	Organization		
Sponsor's Name	Relationship to Sponsor		

INDIVIDUAL TREATMENT PLAN *(Cont'd.)*

This portion to be repeated for each problem

PROBLEM # _____

PROBLEM STATEMENT:

GOAL(S):

OBJECTIVES: (Includes methods and frequency as evidenced by written task, reading assignments, role plays, and the spontaneous sharing of thoughts and feelings):

1. Open date: _____ Target date: _____ Close date: _____

2. Open date: _____ Target date: _____ Close date: _____

3. Open date: _____ Target date: _____ Close date: _____

4. Open date: _____ Target date: _____ Close date: _____

Statement of responsibility: I have participated with my primary counselor in the development of my individual treatment plan. I understand and have agreed to participate in the activities stated herein. I understand the treatment plan may be revised and/or modified at any time during its duration, at which time I will participate in developing the revisions and/or modifications.

I have reviewed the information contained in this treatment plan and concur with its content.

Patient Signature: _____ Date: _____

Primary Counselor: _____ Date: _____

LIP: _____ Date: _____

Patient Name	Rank/Grade	Sex

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SUBSTANCE ABUSE REHABILITATION PROGRAM
AUDIO/VIDEO CONSENT FORM

On certain occasions interviews and treatment sessions may be audio/video taped, and/or observed. The purpose of these procedures is to provide for high quality professional services and for use in training the alcohol counselors.

I, _____, consent to and authorize the production of audio/video tape recordings, closed circuit television, or other observation at the Substance Abuse Rehabilitation Program, _____ (command).

I understand that all information so obtained will be handled in confidence to the extent allowed by law. I understand that I may revoke this consent at any time. Per BUPERS Form 5350/10 (Drug and Alcohol Privacy Act Statement) I further understand that information will not be released to unauthorized agencies or individuals without my expressed, written consent.

_____ _____
Patient Signature Date

_____ _____
Staff Signature Date

Patient Name	Rank/Grade	Sex
SSN/Identification Number	Status	Date of Birth
Branch of Service	Organization	
Sponsor's Name	Relationship to Sponsor	

BUMEDNOTE 5353
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MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE

SUBSTANCE ABUSE REHABILITATION PROGRAM
CLINICAL PROGRESS NOTE

Type of Entry: Medical Referral_____ Initial Contact_____ Assessment_____
Individual Psychotherapy_____ Group Psychotherapy_____
Outpatient Treatment_____ Intensive Outpatient Treatment_____
Pre-treatment Interim Care_____ Walk-in_____ Tx-intake_____

Diagnosis:

Primary Counselor:_____ Date:_____

Patient Name:_____ Patient #:_____ DOB:_____

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	
PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID NO or SSN; Sex; Date of Birth; Rank/Grade.)*		REGISTER NO.	WARD NO.

SUBSTANCE ABUSE REHABILITATION PROGRAM
CONSENT TO OBTAIN INFORMATION

The purpose or need for this information is to assist the staff in my rehabilitation efforts. I understand I may revoke this consent to obtain information at any time and that upon fulfillment of the stated purpose(s); this consent will automatically expire without my expressed revocation. Unless sooner revoked or fulfilled, this consent will expire 1 year from the date signed. Information provided by other professionals will be held strictly confidential and will not be released without my expressed written consent. I realize this communication will reveal my presence in treatment to the person contacted.

Communication between _____ and _____
Internal Program Person, Agency/Designated

ADDRESS
_____

_____
City, State and Zip Code

Attention: _____

ADDRESS
_____

_____
City, State and Zip Code

Attention: _____

As specified and agreed to below:

OBTAIN INFORMATION for the following purpose(s):

_____

_____

Information to be obtained related to my:
_____ Chemical usage _____ Medical history _____ Social history/background
_____ Education _____ Other
Specify: _____

Methods for obtaining authorized information are:
_____ Concerned person questionnaire _____ Written _____ Telephone _____ Other
Specify: _____

Patient Signature: _____ Date: _____

Staff Signature: _____ Date: _____

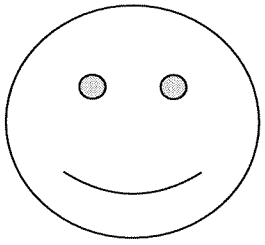
NOTE: This information being requested from you is protected under confidentiality requirement by Federal Law. Federal regulations prohibit disclosure of this information without the expressed written consent of the patient to whom it pertains, or as otherwise permitted by such regulations. A general medical authorization for the release of medical or other information is not sufficient for this purpose.

Patient Name		Rank/Grade	Sex
SSN/Identification Number	Status	Date of Birth	
Branch of Service	Organization		
Sponsor's Name	Relationship to Sponsor		

SUBSTANCE ABUSE REHABILITATION PROGRAM
TREATMENT RECORD
RIGHT COVER PAGE

1. Cover Page
2. Recommendation Letter (Facility Specific – No Sample Provided)
3. Privacy Act
4. Patient Information
5. Screening Tool (e.g., MAST, SASSI, CAGE, CAAPE, MAPP, CIWA-AR)
6. Alcohol and Drug Assessment (Patient Questionnaire)
7. SF-513
8. Referral Forms (Mental Health/DAPA/SACO/CDAR – Facility Specific – Sample Provided)
9. Optional Items (check if contained in this package)

   ☐ a. Significant Other Contact
   ☐ b. Information Release Authorization
   ☐ c. Informed Consent
   ☐ d. Other Pertinent Forms or Documentation



Attach photo

Peer Review: _____
(Signature) (Date)

Director: _____
(Signature) (Date)

PRRC Conducted by: _____
(Signature) (Date)

SUBSTANCE ABUSE REHABILITATION PROGRAM

PRIVACY ACT STATEMENT

This statement is provided in compliance with the provisions of the Privacy Act of 1974 (5 U.S.C. 552a). The Privacy Act requires us to give the following information before we ask you for personal information.

1. Authority. 44 U.S.C. § 3101; 5 U.S.C. § 301; 10 U.S.C. § 978; 42 U.S.C. § 290dd-1, 290dd-2; 42 CFR Chap. I, pt. 2; SECNAVINST 5300.28C; OPNAVINST 5350.4C.

2. Principal Purposes. The information we request from you is intended principally to provide a basis on which to assess your use of alcohol and other drugs, and to provide therapeutic assistance to you as required. The information you provide will become part of your record at this facility.

3. Routine Uses. Under 42 U.S.C. § 290dd-2, any information you provide in connection with your involvement in a substance abuse program shall be confidential and may be disclosed outside the Department of Defense (DOD) only as expressly authorized in that statute. The "Blanket Routine Uses" found at the beginning of the Navy Systems of Records Notices do not apply to these types of records. The interchange of your information within the Uniformed Services is not limited by 42 USC § 290dd-2. The scope of the confidentiality and use of your information within the Department of the Navy (DON) and DOD is explained below at paragraph 7.

4. Effects of not providing the requested information. Disclosure of information is voluntary, but if you fail to disclose any or all information, counselors may be unable to evaluate your drug, and or alcohol situation with the result that you may be considered a treatment failure and discharged from the program. Also, the treatment process requires you to be video/audio taped. If you do not participate in that or any other aspect of the treatment process, you could be considered a treatment failure and discharged from the program. If you are unable or refuse to participate or cooperate in, or fail to complete, a Level II or III alcohol rehabilitation program, or fail to follow a directed aftercare program, you may be processed for administrative separation for treatment failure.

5. Your right to obtain records. You may review or obtain copies of all records retrievable by your name, social security number, or other personal identifier.

6. Non-confidential disclosures. Although most disclosures made as part of any DON substance abuse counseling, treatment or rehabilitation program, and records kept in connection with these programs are confidential, the following are not considered confidential. These disclosures may be used for appropriate administrative or disciplinary action.

a. Homosexual acts as defined in MILPERSMAN 1910-148.

b. Suicidal ideation when a physician or clinical psychologist makes a psychiatric referral.

c. Information disclosed in response to official questioning under any investigation or any administrative or disciplinary proceeding.

d. Disclosure of a past crime, illegal act, or any other incident that places the command or any of its members in jeopardy.

e. Disclosure that any crime or illegal act is about to take place. Such information shall be immediately transmitted to your Commanding Officer (and potential victim, if any).

f. Disclosure of child abuse. State and federal laws, as well as Navy regulations, require the reporting of evidence of child abuse. Suspected or known child abuse must be reported to the Family Advocacy Representative (FAR) and/or civilian Child Protective Service.

Patient Name	Rank/Grade	Sex
SSN/Identification Number	Status	Date of Birth
Branch of Service	Organization	
Sponsor's Name	Relationship to Sponsor	

Privacy Act Statement (Cont'd.)

7. Scope of confidentiality and use of your information

a. General. Except as noted above, disclosures made as part of any DON substance abuse counseling, treatment or rehabilitation program, and records kept in connection with such program, are considered confidential and may not be released outside DOD, subject to some exceptions. There are limitations on how confidential disclosures and records may be used within DOD and DON. Those limitations are described later.

b. Who may access your confidential information. Your Commanding Officer has access to all the information you disclose during your participation in a DON or DOD substance abuse program. Your Commanding Officer may delegate that authority to other command personnel, who may access that information on a "need to know" basis. Other DOD and DON personnel (such as authorized drug and alcohol screening, counseling, and treatment personnel, and medical personnel) who have a "need to know" may also be authorized access to your information for uses consistent with their duties. Disclosures outside DOD are strictly limited.

c. How your confidential information may be used

(1) Use within the program. Authorized personnel within a substance abuse program in which you are involved may use your confidential disclosures and records for identification, diagnosis, prognosis and treatment.

(2) Use at disciplinary proceedings. Confidential disclosures made during the course of this program in some cases may be used against you in disciplinary proceedings.

(3) Use at administrative proceedings. Confidential disclosures made as part of any DON substance abuse counseling, treatment or rehabilitation program, and records kept in connection with such program, may be used against you in administrative discharge proceedings, subject to the following conditions.

(a) If you are a valid, voluntary self-referral to a substance abuse treatment and rehabilitation program, are found to be drug-dependent and seek treatment, you will normally be processed for administrative separation using the notification procedures described in MILPERSMAN 1910-402. The least favorable characterization of service would be a General Discharge (Under Honorable Conditions) unless other UCMJ violations exist.

(b) If you are involuntarily referred to a substance abuse treatment and rehabilitation program, and are found to be involved in drug abuse, you will normally be processed for administrative separation using the Administrative Board procedures unless other UCMJ violations exist. The least favorable characterization of service possible under these procedures is Other Than Honorable.

(4) Other uses. Your Commanding Officer may use any information from your substance abuse treatment and rehabilitation program to modify or revoke your security clearance or take other administrative action. The limitations on use of confidential disclosures you make to authorized substance abuse program personnel do not apply to disclosures you make to anyone else, who may or may not be bound by other confidentiality rules. Likewise, these limitations do not apply to disclosures made in response to official questioning in connection with any investigation or disciplinary proceeding.

Screening/Assessment

Patient Signature: _____ Date _____

Counselor Signature: _____ Date _____

Treatment

Patient Signature: _____ Date _____

Counselor Signature: _____ Date _____

Patient Name	Rank/Grade	Sex

NAVMED 5353/11 (5-2003) (BACK)

SUBSTANCE ABUSE REHABILITATION PROGRAM CLINICAL PACKAGE

PATIENT INFORMATION

Sponsor SSN:_____

Last Name: _____ First Name: _____ MI: _____

Screening Date: ____/____/_____ Facility Code: _____ Staff Number: _____

Previous TX: Yes No If Yes, Where? _____ When? ____/____/_____

Marital Status: Single Married Divorced Widowed Separated

SEX: Male Female Age:_____ Birth Date: ____/____/_____ Education level: _____

RACE: Black White Asian/Pacific Islander Hispanic Native American Other

REFERRAL CONTACT

Name:_____

Command: _____

Telephone: Commercial ( )_____ DSN _____

Patient Telephone: Home ( )_____ Work ( )_____

MILITARY INFORMATION

BRANCH OF SERVICE: Navy Air Force Army Marines Coast Guard National Guard Civilian

Status: Active Duty Reserve Retired TAR Dependent Other

ADSD: ____/____/_____ EAOS: ____/____/_____ PRD: ____/____/_____

Command _____ UIC: _____

City _____ State _____ Zip _____

Telephone: Commercial ( )_____ DSN _____

PRIMARY NEXT OF KIN/EMERGENCY CONTACTS

Name_____

Relation to Patient_____

Street_____ City _____ State _____ Zip _____

Telephone: Work ( )_____ Home ( )_____

Patient Name	Rank/Grade	Sex
SSN/Identification Number	Status	Date of Birth
Branch of Service	Organization	
Sponsor's Name	Relationship to Sponsor	

SUBSTANCE ABUSE REHABILITATION PROGRAM

ALCOHOL AND DRUG ASSESSMENT

1. Have you ever participated in a substance use screening or been treated for a substance related disorder before? YES or NO
If YES, please explain (when, where, why etc)?_____
_____

2. In your own words, why are you here today. _____
_____

3. Describe any learning difficulties you may have and your preferred method of learning.
_____

4. Please use the scale below to describe any physical pain you are currently experiencing:

0	1	2	3	4	5	6	7	8	9	10
No Pain				Moderate Pain					Worst Possible Pain	

5. When you drink/use, how much do you usually drink/use? (Use this chart to help you; place the number of drinks in the blanks. Write other substances on the line beneath.)

HARD LIQUOR	WINE	BEER
____ Shots	____ Glasses of wine	_____ Can/bottles of beer
____ Mixed drinks	____ "Wine coolers"	_____ Qts/ltrs of beer
____ Pints of liquor	____ Bottles of wine	_____ Pitchers of beer
____ Fifths of liquor		

_____
_____

6. How long does it usually take you to drink/use your usual amount? _____

7. What is the most you ever drank/used in a 24 hour period? (Use this chart to help you, place the number of drinks in the blanks; write drugs on the line beneath.)

HARD LIQUOR	WINE	BEER
____ Shots	____ Glasses of wine	_____ Can/bottles of beer
____ Mixed drinks	____ "Wine coolers"	_____ Qts/ltrs of beer
____ Pints of liquor	____ Bottles of wine	_____ Pitchers of beer
____ Fifths of liquor		

_____

Describe the situation/circumstances_____
_____

8. My friends, (circle all that apply), drink/use drugs, advise me, do things that get them in trouble, encourage my treatment involvement, think I have a problem with drinking/drugs, go to treatment for their own use of alcohol or drugs.

Patient Name		Rank/Grade	Sex
SSN/Identification Number	Status	Date of Birth	
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ALCOHOL AND DRUG ASSESSMENT (Cont'd.)

9. Do you resent others talking about your drinking/drug use? YES or NO

10. Are you presently living alone as a result of your drinking/drug use? YES or NO

11. When you drink/use drugs, is it your intention to get drunk/high? YES or NO

12. Please check all that apply and complete the information for each category as requested:

Alcohol	□ Beer □ Liquor □ Wine		
First Use:	Last Use:	How often:	Quantity:
Cannabis	□ Marijuana □ Hashish		
First Use:	Last Use:	How often:	Quantity:
Narcotics	□ Heroin □ Vicodin □ Morphine □ Demerol □ Other:		
First Use:	Last Use:	How often:	Quantity:
Stimulants	□ Methamphetamines □ Amphetamines □ Cocaine □ Crack		
First Use:	Last Use:	How often:	Quantity:
Depressants	□ Valium □ Xanax □ Barbiturates □ Other:		
First Use:	Last Use:	How often:	Quantity:
Hallucinogens	□ LSD □ Mescaline □ Peyote □ Mushrooms □ PCP		
First Use:	Last Use:	How often:	Quantity:
Inhalants	□ Amyl Nitrite □ Glue □ Paint □ Spray cans □ Inhalers		
First Use:	Last Use:	How often:	Quantity:
Designer Drugs	□ MDMA □ Ecstasy □ GHB □ Special K □ Rohypnol		
First Use:	Last Use:	How often:	Quantity:

13 What is/are your drink/drug(s) of preference?_____

14. Do you use tobacco products? (If YES, circle all that apply) YES or NO
Cigarettes/ Cigars/ Chewing Tobacco/ Other

15. How much do you use and how often do you use these products now:
Amount: days/week/month:

Patient Name	Rank/Grade	Sex

ALCOHOL AND DRUG ASSESSMENT (Cont'd.)

16. Who in your family currently has or has had a problem with alcohol, medicines or other drugs? (circle all that apply)

Mother	Father	Brother(s)	Sister(s)	Grandparents
Uncle(s)	Aunt(s)	Guardian	Stepfather	Stepmother
Spouse	Child	Other	None	

17. Have you ever kept drinking or using drugs for long periods without sobering up? YES or NO

18. In the past 12 months, has the amount you drank or used drugs Increased or Decreased

19. Have you found that you need to drink more or use more drugs in order to get drunk or high? YES or NO

If YES, please explain? _____

20. When you consume your normal amount of alcohol do you function _____ than you did in the past? (Circle one)

BETTER THE SAME ABOUT THE SAME WORSE MUCH WORSE

21. Have you ever experienced any of the following when you stopped or cut down on your use of alcohol or drugs? (circle all that apply)

Hand tremors	Severe shakes	See or hear things not there	Rapid heartbeat
Nightmares	Loss of appetite	Jittery/Nervous	Seizures/Convulsions
Weakness	Restlessness	Excessive sweating	Sleeping difficulties
Upset stomach/nausea/vomiting		Other_____	

22. Have you had a drink or taken a drug first thing in the morning, or at other times of the day to steady your nerves or to get rid of a hangover? YES or NO

23. Have you ever had medical help or been seen by the emergency room for alcohol or drug related symptoms (i.e., had a drunk watch, dehydration, vomiting, intoxication, alcohol poisoning, etc.)? YES or NO
If YES, when and where? _____

24. Have there been times when you drank or used drugs more or longer than you intended to? YES or NO

If YES, when was the last time this happened? _____
How often does this happen?_____
Under what circumstances does this happen? _____

Some people make rules for their drinking or drugging (like not using before 5 o'clock; not drinking or using drugs and driving; setting limits (amount of time or money)).

25. Have you ever made rules like that for yourself? YES or NO
If YES, what rules did you make and why?

_____
_____

How successful have you been at following this/these rule(s)? _____

26. Have you ever thought you should cut down on your drinking or other drug use? YES or NO

Patient Name	Rank/Grade	Sex

ALCOHOL AND DRUG ASSESSMENT (Cont'd.)

27. Have you ever attempted to cut back or stop drinking or using drugs? YES or NO

If YES, how many times have you tried to cut back? _____
Why? _____

28. Have you ever hidden your alcohol or drugs from others (i.e., hide beer from your roommates or in several places to ensure you never ran out)? YES or NO
If YES, what did you do? _____

29. Have you ever found yourself scheduling your activities so you could get something to drink or use drugs? YES or NO

30. How much time do you spend drinking/using drugs or recovering from its effects? (i.e., 1 hour per day, 2 days a month, etc.)_____

31. How often do you have hangovers or side effects from your use (i.e., headaches, nausea, etc.)?
_____

32. As a result of your drinking or drug use, have you cut back or stopped doing things that used to be important to you? (e.g., hobbies, sports, family functions) YES or NO

33. Have you found that the people you hang out with have changed as a result of your alcohol or other drug use? YES or NO

34. Do you find that most of your recreational activities involve drinking or drug use before, during, or after your participation in them? YES or NO

35. Have you ever been told that you should not drink or use other drugs because of a medical condition or medications you are taking, and did so anyway? YES or NO
When/why?_____

36. Have you ever been injured or hospitalized due to alcohol or drugs? YES or NO

37. Have you ever had problems with any of the following feelings before(B), during(D) or after(A) a substance use session? (circle all that apply and indicate B, D, or A)

Depression	Fear	Lack of motivation
Anxiety	Nervous	Feeling like killing yourself
Anger	Hurting someone	Feeling like people are out to get you
Feelings of shame/guilt		None of the above

Other _____

38. Has your drinking or drug use affected your sleep? YES or NO

39. Has anyone ever told you that you did something you can't recall after a night of drinking or using drugs? YES or NO

If YES, how often has this happened?_____

40. Has your drinking/drug use ever caused you to miss work or be late to work? YES or NO

41. Has your drinking or drug use ever resulted in your supervisor reprimanding or counseling you? YES or NO

Patient Name	Rank/Grade	Sex

ALCOHOL AND DRUG ASSESSMENT (Cont'd.)

42. Due to drinking or drug use, have you ever had an advancement recommendation withdrawn, evaluation mark lowered, orders modified, or lost a job? YES or NO

43. Have you spent money on drinking or other drugs that should have been spent on other important items? (i.e., food, clothing, bills, etc.) YES or NO

44. Have you ever accidentally hurt or injured yourself or someone else when you have been drinking or using drugs? YES or NO

45. Where do you drink most of the time? BAR HOME FRIENDS OTHER

_____

If you drink at someplace other than where you live, how do you get back home? (Circle as many as apply.)

Walk	How often _____(i.e., 2 times per week)
Bicycle	How often _____
Taxi	How often _____
Drive	How often _____
Friends drive	How often _____

46. Have you ever participated in high-risk activities (driving a motor vehicle, rock climbing, water skiing, etc.) while intoxicated, high, impaired or while recovering from the effects of alcohol or drug use? YES or NO

If YES, when? _____

47. Do you have any past, current or pending military or civilian legal problem or concerns? YES or NO

CHARGES INVOLVING ALCOHOL OR DRUGS: (circle all that apply)

Disorderly	Conduct	Drunk and Disorderly	Public Intoxication
Underage Drinking	DUI/DWI/OUI	Assault	Battery
Open Container	Drug Paraphernalia	Domestic Violence or Abuse	
Urinating in Public	Resisting Arrest	Other_____	

List dates of arrest or detainment(s)	Reason(s)
_____	_____
_____	_____
_____	_____

48. List any military disciplinary actions you have had: (circle all that apply)
Counseling Sessions (written or verbal), Disciplinary Review Board, XO's Mast, Captain's Mast, Court Martial, Letters of Instruction, Letters of Reprimand

List dates of disciplinary action	Reason(s)
_____	_____
_____	_____
_____	_____

Patient Name	Rank/Grade	Sex

ALCOHOL AND DRUG ASSESSMENT (Cont'd.)

49. Have any of the following people expressed concern or commented about your drinking? (circle all that apply)

Parents	Family members	Significant other
Children	Co-workers	Supervisor
Friends	Health care provider	Religious advisor
Other _____		

50. Do you continue to drink or use drugs even though family/friend problems have occurred? (i.e., arguments with your spouse/significant other about your drinking, physical/verbal/emotional abuse, or separation)

51. How often have you felt guilt or remorse over how you have treated others as a result of your alcohol or other drug use? (Circle the closest answer.)

Daily or almost daily Weekly Monthly Less than Monthly Never

52. Have you gotten into physical fights as a result of your drinking or drug use? YES or NO

Other Concerns

53. Do you currently have concerns in any of the following: (Circle all that apply.)

Physical	Psychological	Spirituality
Medical	Family	Education
Nutrition	Relationships	Legal
Physical Fitness	Social Support	Sexual
Leisure	Recreational	Vocational
Military Service	Financial	Other

Please explain: _____

_____

54. Are you having thoughts of harming others or yourself? YES or NO

55. In the past I had mental health treatment/counseling for: _____

56. On a scale of 1 – 10, 1 being LOW, 10 being HIGH, how would you rate your level of motivation for treatment if it were recommended? _____

Signature: _____ Date: _____

Counselor: _____ Date: _____

Patient Name	Rank/Grade	Sex

MEDICAL RECORD	CONSULTATION SHEET

REQUEST

TO: SUBSTANCE ABUSE REHABILITATION PROGRAM	FROM: (Requesting physician or activity)	DATE OF REQUEST

REASON FOR REQUEST: *(Complaints and findings)*

This_____ year old, _____ (marital status), male / female, active duty / family member / retiree, _____ (rank), _____ (service),

with_____ year(s) active service, was referred for a substance abuse evaluation due to:

PROVISIONAL DIAGNOSIS:

DOCTOR'S SIGNATURE	APPROVED	PLACE OF CONSULTATION ❑ BEDSIDE ❑ ON CALL	❑ ROUTINE ❑ TODAY ❑ 72 HOURS ❑ EMERGENCY

CONSULTATION REPORT

RECORD REVIEWED YES ☐ NO ☐ PATIENT EXAMINED YES ☐ NO ☐ TELEMEDICINE YES ☐ NO ☐

CHIEF COMPLAINT: Regarding problems, the patient said "

HISTORY OF SUBSTANCE USE:

SUBSTANCE	AGES USED	AMOUNTS	FREQUENCY
			_____times per_____

Last alcohol or substance use (date and amount):
Recent withdrawal symptoms:

Tobacco use:
Amount _____ PPD. Age started _____
Withdrawal symptoms _____. Attempts to limit use:

SIGNATURE AND TITLE	DATE

HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT	DEPART. /SERVICE OF PATIENT

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME	SPONSOR'S ID NUMBER *(SSN or Other)*

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name – last, first, middle; ID No (SSN or other); Sex; Date of Birth; Rank/Grade.)*	REGISTER NO.	WARD NO.

CONSULTATION SHEET
Medical Record
STANDARD FORM 513 (REV. 4-98)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)
NAVMED O/P 5353/14 (5-2003)

Enclosure (13)

BIOPSYCHOSOCIAL INDICATORS OF A SUBSTANCE USE PROBLEM

Substance Abuse:

Recurrent substance use causing a failure to fulfill obligations at work, school or home, as evidenced by:

Recurrent substance use in hazardous situations:

Recurrent substance related legal problems:

Continued use despite having persistent or recurrent social or interpersonal problems:

Substance Dependence:

Needs increased amount to achieve the same effect, or decreased effect with use of the same amount, as evidenced by:

Withdrawal evidenced by circled items: shakes, sweats, sleep problems, restlessness, seizures, hallucinations, nausea/stomach problems.

Substance taken in larger amounts or over a longer period than intended:

Desire or unsuccessful efforts to cut down or control use:

Excessive time spent obtaining, using or recovering from substance use:

Social, work or leisure activities given up due to substance use:

Substance use in spite of awareness it aggravates physical or psychological problems:

RELEVANT PAST HISTORY:

Childhood was:

Family psychiatric or substance abuse history:

Spiritual history:

MEDICAL HISTORY (from Outpatient Medical Record review):

Pertinent history of physical problems:

Mental health problems and treatment (including substance abuse treatment):

Current medications and doses:

MENTAL STATUS EXAM:

Grooming problems _____ Motor aberrations _____ Speech aberrations _____

Manner _____ Mood _____ Affect _____

Thought process and content aberrations _____

Hallucinations _____ Cognitive functioning problems _____

Problems with insight / judgement / impulse control _____

Suicidal ideation/plan _____

Homicidal ideation/plan/target _____Contract for safety_____

FORMULATION/ASAM PPC:

1. Withdrawal risk is: low / medium / high.
   Describe if medium or high:

2. Bio-medical issues:

3. Emotional or behavioral issues:

4. Readiness to change: very low/ low/ moderate/ moderately high/ high.
   Describe:

FORMULATION/ASAM PPC (CONTINUED):

5. Potential for further substance related incidents: very low / low / moderate / moderately high / high.
   Describe:

6. Issues of concern regarding recovery environment:

7. Is this visit deployment related? Yes____ No____

DIAGNOSES:

Axis I:

Axis II:

Axis III:

Axis IV:

Axis V: GAF = _____ (current)

RECOMMENDATIONS:

1. Substance abuse treatment is: indicated / not indicated.

a) The level of treatment recommended is: Impact / Outpatient / Intensive Outpatient / Residential

b) Treatment may be scheduled by calling SARP

2. Other recommendations:

a)

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name – last, first, middle; ID No (SSN or other); Sex; Date of Birth; Rank/Grade.)*	REGISTER NO.	WARD NO.

STANDARD FORM 513 (REV. 4-98)
NAVMED O/P 5353/14 (5-2003

SUBSTANCE ABUSE REHABILITATION PROGRAM

SIGNIFICANT OTHER CONTACT AUTHORIZATION

I_____ authorize SARP, _____ to make personal contact with _____ to ascertain my substance abuse history in order to assist in determining my need for substance abuse treatment, and for the development of my individual rehabilitation/treatment plan if required. I understand that the purpose of this contact is to assist the drug and alcohol counselors at SARP, _____ to better understand my situation, and to more accurately identify and address potential problems with alcohol or other drugs. I also understand that any information regarding my substance abuse history is to be used strictly to determine my need for substance abuse treatment and to aid in the development of my treatment plan.

_____	_____	_____
PATIENT'S NAME (PRINTED)	PATIENT'S SIGNATURE	DATE

_____
PATIENT'S SSN

_____	_____	_____
COUNSELOR'S NAME (PRINTED)	COUNSELOR'S SIGNATURE	DATE
_____	_____	_____
COUNSELOR'S NAME (PRINTED)	COUNSELOR'S SIGNATURE	DATE

Patient Name		Rank/Grade	Sex
SSN/Identification Number	Status	Date of Birth	
Branch of Service	Organization		
Sponsor's Name	Relationship to Sponsor		

SUBSTANCE ABUSE REHABILITATION PROGRAM

INFORMATION RELEASE AUTHORIZATION

I,_____ hereby authorize_____,
(patient's name) (program name)

its director or designee, to release information contained in my treatment records to the individuals or organizations and only under the conditions listed below:

1. Name of person(s) or organization(s) to whom disclosure is to be made: _____

_____

_____

2. Specific type of information to be disclosed: _____

_____

_____

3. The purpose and need for such disclosure: _____

_____

_____

4. This consent is subject to revocation at any time.

5. Without expressed revocation this consent expires for the following specified reasons:

   a. Date:___/___/___

   b. Event:_____

   c. Condition:_____

_____ _____
Witnessed By Patient Signature

_____ _____
Date Witnessed Date Signed

Patient Name		Rank/Grade	Sex
SSN/Identification Number	Status	Date of Birth	
Branch of Service	Organization		
Sponsor's Name	Relationship to Sponsor		

HEALTH RECORD **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE **SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION**

_____ Substance Abuse Rehabilitation Program (SARP),

INFORMED CONSENT

DATE: _____

You have either been given a substance abuse or dependence diagnosis, or it has been found that you would benefit from education on substance abuse. There are a variety of treatments for substance use problems. Each treatment has its own potential risks and benefits. Medications, which are used infrequently, are almost always used in combination with counseling. Some types of one-on-one counseling have been proven to be helpful. Group counseling is the most common type of treatment for substance use problems. At SARP, we combine educational workshops, social support efforts, and individual and group counseling.

Mild substance abuse disorders sometimes resolve with interventions to limit substance use; however, there is a risk of worsening psychological, social, and physical problems if abuse recurs. You may choose to have no treatment at all, but it is likely your problems would worsen.

If you have any questions about this assessment or possible treatments, please ask the clinician who gave you this form, or seek more information from respected sources.

Please check either box 'a' or 'b' below, and then sign this form:

a. I consent to treatment at SARP. ☐

b. I do not consent to treatment at this time. ☐

_____
Patient Signature

Patient Name		Rank/Grade	Sex
SSN/Identification Number	Status	Date of Birth	
Branch of Service	Organization		
Sponsor's Name	Relationship to Sponsor		

STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1
NAVMED O/P 5353/17 (5-2003)

SUBSTANCE ABUSE REHABILITATION PROGRAM

From: Substance Abuse Rehabilitation Program

To:

Subj: RECOMMENDED CONTINUING CARE PLAN

Ref: (a) OPNAVINST 5350.4C

1. Per reference (a), you are provided with the following Continuing Care Treatment Plan to assist you in your recovery.

( ) End of Treatment Diagnosis: Alcohol Abuse/Dependence

( ) Meet with the Command Drug and Alcohol Program Advisor

( ) Attend _____ meetings at least _____ times weekly for _____ months. (If Narcotics Anonymous is recommended but not available, Alcoholics Anonymous may be substituted.)

( ) Participate in a formalized Continuing Care group for a maximum of _____ weeks.

2. Should you have questions concerning your individual Continuing Care Treatment Plan, you may contact your counselor by mail or telephone. Assistance is also available through your command DAPA.

3. A copy of this recommended Continuing Care Treatment Plan has been provided to your commanding officer and command DAPA. Failure to comply with your Continuing Care Treatment Plan may result in unsuccessful completion of treatment and possible administrative processing.

_____
COUNSELOR

Acknowledgement: Date: _____

I have read and fully understand the contents of my personal Continuing Care Treatment Plan and do / do not agree. (Circle one)

Comments:

_____

_____

_____

Copy to:
Commanding Officer
DAPA

_____
Patient Signature

Patient Name		Rank/Grade	Sex
SSN/Identification Number	Status	Date of Birth	
Branch of Service	Organization		
Sponsor's Name	Relationship to Sponsor		

SUBSTANCE ABUSE REHABILITATION PROGRAM

SAMPLE

SARP REFERRAL FORM

I, _____, agree that I will not harm myself or another person before my next appointment. I understand that there are alternatives to suicide and that there are resources available to me. Should my suicidal thoughts return or intensify, I will seek the help of a peer, supervisor, staff member, or medical professional at the agencies listed below.

_____ _____
(PATIENT'S NAME) (DATE)

_____ _____
(WITNESS) (DATE)

This patient has been informed regarding available supportive resources and alternatives to suicide. These include:

MENTAL HEALTH DEPARTMENT----------
SICKCALL----------
CARE PLUS CLINIC----------
CHAPLAIN----------
FAMILY SEVICE CENTER----------
ON BASE AMBULANCE (SUBASE FIRE DEPT)---- ----------
OFF BASE AMBULANCE (INCLUDING NAVY HOUSING) ------
CRISIS LINE----------

This case has been discussed with Dr._____, the on-call mental health provider at_____. The recommended disposition:

a) Immediate evaluation by the on-call provider

b) 72-hour evaluation by the on-call provider

c) Routine evaluation by a mental health provider

Patient Name	Rank/Grade	Sex
SSN/Identification Number	Status	Date of Birth
Branch of Service	Organization	
Sponsor's Name	Relationship to Sponsor	